

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-022060
STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

5106

FILED MAY 17 1963

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY Mo		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis Mo.		Length of stay in 1b lmo	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis Chronic Hosp		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Florence Middle Peters Last		4. DATE OF DEATH Month 5-10-63 Day Year	
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10-2-1877
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Stenographer		11. BIRTHPLACE (City and state or country) Mo	
13a. FATHER'S NAME Thomas McCormack		13b. MOTHER'S MAIDEN NAME Julia Quinn	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates)		16. SOCIAL SECURITY NO. 32B	
17. INFORMANT Charles Peters		Address 4497 Pershing Ave.	
18. CAUSE OF DEATH (Enter only one cause per item for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia with Abscesses</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>420 OF</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Inter trochanteric fracture of Left Hip</u>			INTERVAL BETWEEN ONSET AND DEATH 5 days year
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>"Thrown down by another patient"</u>		20c. TIME OF INJURY Hour Month, Day, Year 2/28/63	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 23 BLISS HOSPITAL	
21. I attended the deceased from 4-10-63 to 5-10-63 and last saw her him alive on 5-10-63 Death occurred at 12:05 am.		22a. SIGNATURE George M. Tanaka, m.d. (Degree or title)	
22b. ADDRESS 5600 Arsenal		22c. DATE SIGNED 5/10/63	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/13/63	
23c. NAME OF CEMETERY OR CREMATORY Calvary		23d. LOCATION (City, town, or county) City	
24. FUNERAL DIRECTOR Arthur J. Donnelly		25. DATE RECD. BY LOCAL REG. MAY 11 1963	
ADDRESS 3840 Lindell		REGISTRAR'S SIGNATURE Paul Smith, M.D.	

USE BLACK INK
OR
TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Ernest J. Nilbomson

Licensed Embalmer No.

3565

P. O. Address

3840 Lindell

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.